

females (300 per 100,000). This is the same rate as was found for black females in Tennessee from the CBW survey.

Drug treatment clinic data (site #1), again from Memphis, yielded an overall estimate of 1.9% of HIV prevalence among tested clients. The range was from 0.7% to 4.6%. Prevalence was highest among black males (3.1%), followed by black females (2.1%). Again, these overall estimates are similar to self-reported HIV/AIDS prevalence from behavioral risk surveys among Tennessee adults who inject drugs.

STD clinic data yielded overall estimates in Memphis of 1.4%. Nashville STD clinic data showed a 1.9% prevalence, and Chattanooga clinic data a prevalence of 1.2%. In these clinic samples, white males had the highest seropositivity, with female positivity substantially lower. HIV seropositive rates for white males were 3.4% in Memphis, 3.5% in Nashville and 2.5% in Chattanooga. Black males had HIV prevalence estimates based on this data source of 1.6% in Memphis, 2.6% in Nashville and 1.6% in Chattanooga. Seropositive rates were higher among black females than white females in Memphis (0.9% compared to 0.5%, respectively) and in Nashville (.75% and .25% respectively). Rates were relatively close in Chattanooga (0.3% among black females compared to 0.2% among white females).

### **3.3.3.1. Rapid Assessment of Prevalence (RAP)**

RAP is a blinded survey designed to provide a quick snapshot of HIV prevalence among people visiting specific sites, such as STD clinics, drug treatment centers, correctional facilities and community health centers. This survey is sponsored by CDC in cooperation with the Tennessee Department of Health. The RAP data were collected in two public STD/HIV clinics, one serving Memphis/Shelby County and the other serving Chattanooga/Hamilton County. In both clinics, blood samples were drawn from the first 1,000 consecutive clinic patrons without regard to the reason for their visit. Patients known to have HIV or AIDS were to be included in the blood sampling, as were people seeking diagnosis or treatment of any sexually transmitted disease or HIV. These surveys were required to include a minimum of 300 women. Patients were to be included in the survey only once during the survey period (from one to two months).

The strengths of the RAP survey include the gathering of anonymous, unlinked seroprevalence information to determine the rate of HIV-positives for all patients in each survey category (e.g., sex, race, age-group, etc.). Of persons testing HIV-positive, it can be determined how many presented for reasons other than HIV/AIDS, how many did not request an HIV test and had not received an HIV test in the past. Among these, a calculation can be done of the number reporting risk behavior by sex, by age and by race, and by client behaviors. The number who tested negative at a date less than 2 months before the study can be calculated, indicating an awareness of the threat of HIV, but continued risk-taking or denial.